

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0018408</u></p> <p>Facility Name: <u>THE LAMBS</u></p> <p>Address: <u>P.O. Box 520</u> <u>Libertyville</u> <u>60048</u> Number City Zip Code</p> <p>County: <u>Lake</u></p> <p>Telephone Number: <u>847-362-4636</u> Fax # <u>847-362-0742</u></p> <p>IDPA ID Number: <u>36-2474251001</u></p> <p>Date of Initial License for Current Owners: _____</p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501C3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>SCOTT M. FREEMAN, C.F.O.</u> Telephone Number: <u>847-362-4636</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2001</u> to <u>6/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1283 678 1923 716">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1283 716 1923 753">(Type or Print Name) <u>SCOTT M. FREEMAN</u></td> </tr> <tr> <td data-bbox="1150 753 1283 829"></td> <td data-bbox="1283 753 1923 790">(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td data-bbox="1150 829 1283 1040" rowspan="4">Paid Preparer</td> <td data-bbox="1283 829 1923 867">(Signed) _____ (Date)</td> </tr> <tr> <td data-bbox="1283 867 1923 904">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 904 1923 941">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1283 941 1923 1040">(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date)	(Type or Print Name) <u>SCOTT M. FREEMAN</u>		(Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Date)	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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Paid Preparer	(Signed) _____ (Date)																																		
	(Print Name and Title) _____																																		
	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # ()																																		

STATE OF ILLINOIS

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Facility Name & ID Number THE LAMBS# 0018408 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>40</u>	Intermediate/DD	<u>40</u>	<u>14,600</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>40</u>	TOTALS	<u>40</u>	<u>14,600</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>12,980</u>			<u>12,980</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,980</u>			<u>12,980</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.90%

D. How many bed-hold days during this year were paid by Public Aid?

1,620 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
_____F. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 03/03/76

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

THE LAMBS

0018408

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	11,027			11,027		11,027		11,027			1
2	Food Purchase		119,493		119,493		119,493		119,493			2
3	Housekeeping	57,315	6,034		63,349		63,349		63,349			3
4	Laundry		592	4,350	4,942		4,942		4,942			4
5	Heat and Other Utilities			33,423	33,423		33,423		33,423			5
6	Maintenance		24,807		24,807	42,571	67,378		67,378			6
7	Other (specify):* Grounds/Alternative Day Program		10,229		10,229	41,498	51,727		51,727			7
8	TOTAL General Services	68,342	161,155	37,773	267,270	84,069	351,339		351,339			8
	B. Health Care and Programs											
9	Medical Director	44,197	5,640	17,351	67,188		67,188		67,188			9
10	Nursing and Medical Records	181,209			181,209		181,209		181,209			10
10a	Therapy			2,114	2,114		2,114		2,114			10a
11	Activities	269,409	3,981	417	273,807	47,329	321,136		321,136			11
12	Social Services	183,104			183,104	36,259	219,363		219,363			12
13	Nurse Aide Training											13
14	Program Transportation			271	271	24,372	24,643		24,643			14
15	Other (specify):* Behavior Management/Security					26,195	26,195		26,195			15
16	TOTAL Health Care and Programs	677,919	9,621	20,153	707,693	134,155	841,848		841,848			16
	C. General Administration											
17	Administrative	23,397	3,995	8,790	36,182	272,604	308,786		308,786			17
18	Directors Fees											18
19	Professional Services			578	578	6,361	6,939		6,939			19
20	Dues, Fees, Subscriptions & Promotions			5,712	5,712		5,712		5,712			20
21	Clerical & General Office Expenses			1,745	1,745		1,745		1,745			21
22	Employee Benefits & Payroll Taxes			122,589	122,589	67,823	190,412		190,412			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,488	1,488		1,488		1,488			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			19,959	19,959		19,959		19,959			26
27	Other (specify):*											27
28	TOTAL General Administration	23,397	3,995	160,861	188,253	346,788	535,041		535,041			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	769,658	174,771	218,787	1,163,216	565,012	1,728,228		1,728,228			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number THE LAMBS

#0018408

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			43,608	43,608		43,608		43,608			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,897	8,897		8,897		8,897			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			52,505	52,505		52,505		52,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,696	102,696		102,696		102,696			42
43	Other (specify):*			565,012	565,012	(565,012)						43
44	TOTAL Special Cost Centers			667,708	667,708	(565,012)	102,696		102,696			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	769,658	174,771	939,000	1,883,429		1,883,429		1,883,429			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number THE LAMBS

0018408

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$		38
39						39
40	Gift and Coffee Shops	X				40
41	Barber and Beauty Shops	X				41
42	Laboratory and Radiology	X				42
43	Prescription Drugs	X				43
44	Exceptional Care Program	X				44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

THE LAMBSID# 0018408Report Period Beginning: 7/1/2001Ending: 6/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

6/30/2002

[illegible]

Summary B

6/30/2002

6/30/2002

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Lambs Residence Two	Libertyville	Sec 8 Housing
				Benjamin Greenfield	Libertyville	Support Program

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Food Purchase	\$ 119,493		100.00%	\$ 119,493	\$ *	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 119,493			\$ 119,493	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE LAMBS # 0018408 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE LAMBS# 0018408

Report Period Beginning:

7/1/2001Ending: 7/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See attached Exhibit A				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	IL-Health Facilities		X	Refinance		12/18/90	\$ 155,000	\$ 97,000	2010	7.5000	\$ 8,897	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 155,000	\$ 97,000			\$ 8,897	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 155,000	\$ 97,000			\$ 8,897	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number THE LAMBS

0018408 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	10		
	2000	11		
	2001	12		
			FOR OHF USE ONLY	
			13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	THE LAMBS	COUNTY	Lake
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CONTACT PERSON REGARDING THIS REPORT

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Index Number	Property Description	Total Tax	

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building lot	37,500	1971	\$ 20,000	1
2					2
3	TOTALS	37,500		\$ 20,000	3

Facility Name & ID Number THE LAMBS

0018408

Report Period Beginning:

7/1/2001

Ending:

6/30/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	40		1976	1976	\$ 372,090	\$ 9,302	40	\$ 9,302	\$	\$ 253,530	4
5			1980	1980	1,249	31	40	31		718	5
6			1981	1981	2,220	56	40	56		1,166	6
7			1983	1983	957	24	40	24		467	7
8			1988	1988	6,431	161	40	161		2,331	8
	Improvement Type**										
9	ICF Bike Shed			Jan-87	3,334	167	20	167		2,583	9
10	ICF Bike Shed			Jan-88	378	19	20	19		274	10
11	ICF Sidewalk			Jan-90	736	37	20	37		460	11
12	ICF Parking Lot Seal			Jan-92	1,885	94	20	94		990	12
13	Remodel Office			Jan-84	1,429	71	20	71		983	13
14	General remodel			Jan-84	2,434	122	20	122		1,673	14
15	Remodel Ladies Room			Jan-84	11,199	560	20	560		6,887	15
16	Nurses/Medroom Remodel			Jan-85	2,475	124	20	124		1,522	16
17	Remodel men's restroom			Jan-85	8,166	408	20	408		4,627	17
18	Kitchen remodel			Jan-86	17,536	877	20	877		5,449	18
19	Laundry remodel			Jan-95	2,992	150	20	150		840	19
20	Bathroom remodel			Jan-95	5,958	298	20	298		1,673	20
21	New Door			Aug-01	1,074	89	10	89		89	21
22	Furnish & Install Hub & Data Drop			Oct-01	1,277	85	10	85		85	22
23	Replace Existing door & frame, switch assembly			Nov-01	4,935	329	10	329		329	23
24	ICF Restoration Project			Dec-01	582,986	17,548	10	17,548		17,548	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,031,741	\$ 30,552		\$ 30,552	\$	\$ 304,224	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,031,741	\$ 30,552		\$ 30,552	\$	\$ 304,224	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,031,741	\$ 30,552		\$ 30,552	\$	\$ 304,224	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 88,445	\$ 12,568	\$ 12,568	\$	3, 5, 10	\$ 65,565	71
72	Current Year Purchases	4,978	488	488		3.5	488	72
73	Fully Depreciated Assets	44,054					44,054	73
74								74
75	TOTALS	\$ 137,477	\$ 13,056	\$ 13,056	\$		\$ 110,107	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residential	1997 Dodge Caravan	1997	\$ 15,500	\$	\$	\$	3	\$ 15,500	76
77										77
78										78
79										79
80	TOTALS			\$ 15,500	\$	\$	\$		\$ 15,500	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,204,718	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,608	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,608	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 429,831	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2003 \$ _____

13. _____/2004 \$ _____

14. _____/2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2	3	4
		Facility				
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 652,367	\$ 1,282,204	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 18,137)	1,171,683	1,171,683	3
4	Supply Inventory (priced at cost)	213,176	213,176	4
5	Short-Term Investments	645,971	2,367,049	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	73,468	73,468	7
8	Accounts Receivable (owners or related parties)	159,567	159,567	8
9	Other(specify): <u>Pledges/Other</u>	24,082	163,759	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,940,314	\$ 5,430,906	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	301,037	1,360,008	12
13	Land	1,447,987	1,788,587	13
14	Buildings, at Historical Cost	4,912,759	4,912,759	14
15	Leasehold Improvements, at Historical Cost	3,299,963	3,299,963	15
16	Equipment, at Historical Cost	3,156,480	3,156,480	16
17	Accumulated Depreciation (book methods)	(5,988,367)	(5,988,367)	17
18	Deferred Charges	6,673	6,673	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Pledges/Bequests/Tru</u>)	36,548	342,640	22
23	Other(specify): <u>Automobiles, Arts, CIP</u>	522,576	522,576	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,695,656	\$ 9,401,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,635,970	\$ 14,832,225	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 174,003	\$ 174,003	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	18,485	18,485	29
30	Accrued Salaries Payable	534,459	534,459	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses/ Other</u>	92,997	98,964	36
37	<u>Deferred Revenue</u>	70,200	70,200	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 890,144	\$ 896,111	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	186,072	186,072	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Liabilities under Trust Agreement</u>		161,387	43
44	<u>Annuity Interest Obligation</u>	244	244	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 186,316	\$ 347,703	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,076,460	\$ 1,243,814	46
47	TOTAL EQUITY (page 18, line 24)	\$ 9,559,510	\$ 13,588,411	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,635,970	\$ 14,832,225	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,918,287	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,918,287	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(154,460)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Net Income(Loss) from Operations-Other	(650,853)	15
16	Other (describe) Restricted Contributions	475,437	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (329,876)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,588,411	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,728,969	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,728,969	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,728,969	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	351,339	31
32	Health Care	841,848	32
33	General Administration	535,041	33
B. Capital Expense			
34	Ownership	52,505	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	102,696	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,883,429	40
41	Income before Income Taxes (line 30 minus line 40)**	(154,460)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (154,460)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number THE LAMBS

0018408

Report Period Beginning: 7/1/2001

Ending:

6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,936	2,080	\$ 44,197	\$ 22.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,706	9,272	181,209	20.81	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,908	16,394	220,748	14.81	10
11	Social Service Workers					11
12	Dietician	507	539	11,027	21.75	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	3,737	4,293	48,661	13.02	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	5,841	6,133	57,315	9.81	18
19	Laundry					19
20	Administrator	956	1,040	23,397	24.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,809	10,400	146,944	14.98	28
29	Resident Services Coordinator	1,748	2,080	36,160	20.69	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	48,148	52,231	\$ 769,658 *	\$ 14.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		13,800	L9-C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,420	L9-C3	39
40	Physical Therapy Consultant	6	780	L10A-C3	40
41	Occupational Therapy Consultant	15	737	L10A-C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	597	L10A-C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychiatrist	6	1,006	L9-C3	46
47	Psychologist		125	L9-C3	47
48					48
49	TOTAL (lines 35 - 48)	37	\$ 19,465		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number THE LAMBS

STATE OF ILLINOIS

0018408

Report Period Beginning: 7/1/2001

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Ending: 6/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 102,696
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Blackman Kallick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? _____
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.